AMENDED IN SENATE APRIL 9, 2014

SENATE BILL No. 964

Introduced by Senator Hernandez

February 10, 2014

An act to amend Section ~~1380.3~~ *1367.03* of, ~~and~~ to add Sections 1380.4, 1380.5, ~~and~~ 1380.6, *and 1380.7* to, *and to repeal Section 1380.3 of,* the Health and Safety Code, *and to amend Section 14087.95 of the Welfare and Institutions Code,* relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 964, as amended, Hernandez. Health care service plans: *timeliness standards:* medical surveys.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. ~~Existing law establishes the California Health Benefit Exchange for the purpose of facilitating the enrollment of qualified individuals and small employers in qualified health plans.~~ *One of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed health care plans, including through county organized health systems. Existing law specifies that these county organized health systems are exempt from the Knox-Keene Health Care Service Plan Act of 1975.*

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 *(Knox-Keene Act)*, provides for the licensure and regulation of health care service plans by the Department of Managed Health ~~Care. Existing~~ *Care and makes a willful violation of the act a crime. Existing law requires the department to adopt standards for timeliness of access to care and requires that contracts between health care service plans and*

providers ensure compliance with those standards. Existing law requires health care service plans to annually report to the department on compliance with those standards in a manner specified by the department. Under existing law, every 3 years, the department is required to review information regarding compliance with those standards and make recommendations for changes that further protect enrollees.

This bill would eliminate the requirement that the department make recommendations for changes that further protect enrollees, would require the department to review information regarding compliance with the timeliness standards, including any waivers or alternative standards granted to plans, on an annual basis, and would require the department to annually post its findings from that review on its Internet Web site commencing December 1, 2016. The bill would require health care service plans, in making reports to the department on compliance with the timeliness standards, to use standardized survey methodology if developed by the department. The bill would also require a contract between a county organized health systems established under the Medi-Cal program and a provider to ensure compliance with the timeliness standards adopted by the department and would require the county organized health system to annually report to the department on compliance with those standards. By expanding the scope of a crime and imposing a new duty on counties, the bill would impose a state-mandated local program.

Existing law *establishes the California Health Benefit Exchange for the purpose of facilitating the enrollment of qualified individuals and small employers in qualified health plans. The Knox-Keene Act* requires the department to periodically conduct an onsite medical survey of the health delivery system of each ~~plan. Existing law~~ *health care service plan and* exempts a plan that provides services solely to Medi-Cal beneficiaries from the survey upon submission to the department the medical survey audit conducted by the State Department of Health Care Services as part of the Medi-Cal contracting process.

This bill ~~would specify that a plan that provides services solely to Medi-Cal beneficiaries is not exempt from the medical survey with respect to quality management, utilization review, timely access, network adequacy, and any other requirements related to access and availability, except as specified. The bill~~ would *eliminate that exemption, would* require a plan that provides services to Medi-Cal beneficiaries~~,~~ ~~except for a plan that serves Medi-Cal beneficiaries exclusively,~~ and a

plan that provides services to enrollees in the California Health Benefit Exchange to be surveyed ~~separately with respect to those products~~ *by those product lines distinct from other product lines and to be annually reviewed with respect to those product lines for compliance with accessibility and availability of services, continuity of care, and quality management, as specified*. The bill would also require a plan that provides services to Medi-Cal beneficiaries through specified programs to be surveyed annually with respect to *the populations enrolled in* those products until 5 years after completion of initial enrollment in those products, as specified. *The bill would authorize the department to coordinate these surveys and reviews conducted with respect to Medi-Cal managed care plans with the State Department of Health Care Services, provided that the coordination does not result in a delay of the surveys or reviews or the failure of the department to conduct the surveys or reviews.*

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

SECTION 1. Section 1367.03 of the Health and Safety Code is amended to read:

1367.03. (a) Not later than January 1, 2004, the department shall develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner. In developing these regulations, the department shall develop indicators of timeliness of access to care and, in so doing, shall consider the following as indicators of timeliness of access to care:

(1) Waiting times for appointments with physicians, including primary care and specialty physicians.

(2) Timeliness of care in an episode of illness, including the timeliness of referrals and obtaining other services, if needed.

(3) Waiting time to speak to a physician, registered nurse, or other qualified health professional acting within his or her scope of practice who is trained to screen or triage an enrollee who may need care.

(b) In developing these standards for timeliness of access, the department shall consider the following:

(1) Clinical appropriateness.

(2) The nature of the specialty.

(3) The urgency of care.

(4) The requirements of other provisions of law, including Section 1367.01 governing utilization review, that may affect timeliness of access.

(c) The department may adopt standards other than the time elapsed between the time an enrollee seeks health care and obtains care. If the department chooses a standard other than the time elapsed between the time an enrollee first seeks health care and obtains it, the department shall demonstrate why that standard is more appropriate. In developing these standards, the department shall consider the nature of the plan network.

(d) The department shall review and adopt standards, as needed, concerning the availability of primary care physicians, specialty physicians, hospital care, and other health care, so that consumers have timely access to care. In so doing, the department shall consider the nature of physician practices, including individual and group practices as well as the nature of the plan network. The department shall also consider various circumstances affecting the delivery of care, including urgent care, care provided on the same day, and requests for specific providers. If the department finds that health care service plans and health care providers have difficulty meeting these standards, the department may make recommendations to the Assembly Committee on Health and the Senate Committee on Insurance of the Legislature pursuant to subdivision (i).

(e) In developing standards under subdivision (a), the department shall consider requirements under federal law, requirements under other state programs, standards adopted by other states, nationally recognized accrediting organizations, and professional associations. The department shall further consider the needs of rural areas,

specifically those in which health facilities are more than 30 miles apart and any requirements imposed by the State Department of Health Care Services on health care service plans that contract with the State Department of Health Care Services to provide Medi-Cal managed care.

(f) (1) Contracts between health care service plans and health care providers shall ~~assure~~ *ensure* compliance with the standards developed under this section. These contracts shall require reporting by health care providers to health care service plans and by health care service plans to the department to ensure compliance with the standards.

(2) Health care service plans shall report annually to the department on compliance with the standards in a manner specified by the department. The reported information shall allow consumers to compare the performance of plans and their contracting providers in complying with the standards, as well as changes in the compliance of plans with these standards.

(3) In making reports to the department pursuant to this subdivision, health care service plans shall use standardized survey methodology if developed by the department.

(g) (1) When evaluating compliance with the standards, the department shall focus more upon patterns of noncompliance rather than isolated episodes of noncompliance.

(2) The director may investigate and take enforcement action against plans regarding noncompliance with the requirements of this section. Where substantial harm to an enrollee has occurred as a result of plan noncompliance, the director may, by order, assess administrative penalties subject to appropriate notice of, and the opportunity for, a hearing in accordance with Section 1397. The plan may provide to the director, and the director may consider, information regarding the plan's overall compliance with the requirements of this section. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45. The director shall periodically evaluate grievances to determine if any audit, investigative, or enforcement actions should be undertaken by the department.

(3) The director may, after appropriate notice and opportunity for hearing in accordance with Section 1397, by order, assess

administrative penalties if the director determines that a health care service plan has knowingly committed, or has performed with a frequency that indicates a general business practice, either of the following:

(A) Repeated failure to act promptly and reasonably to assure timely access to care consistent with this chapter.

(B) Repeated failure to act promptly and reasonably to require contracting providers to assure timely access that the plan is required to perform under this chapter and that have been delegated by the plan to the contracting provider when the obligation of the plan to the enrollee or subscriber is reasonably clear.

(C) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed warranted by the director to enforce this chapter.

(4) The administrative penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(h) The department shall work with the patient advocate to assure that the quality of care report card incorporates information provided pursuant to subdivision (f) regarding the degree to which health care service plans and health care providers comply with the requirements for timely access to care.

~~(i) The department shall report to the Assembly Committee on Health and the Senate Committee on Insurance of the Legislature on March 1, 2003, and on March 1, 2004, regarding the progress toward the implementation of this section.~~

~~(j) Every three years, the~~

(i) The department shall *annually* review information regarding compliance with the standards developed under this section ~~and shall make recommendations for changes that further protect enrollees~~, *including any waivers or alternative standards granted to a plan pursuant to this section. By December 1, 2016, and annually thereafter, the department shall post its findings from that review on its Internet Web site.*

SEC. 2. Section 1380.3 of the Health and Safety Code is repealed.

~~1380.3. Notwithstanding Section 1380, any plan that provides services solely to Medi-Cal beneficiaries pursuant to Chapter 8~~

~~(commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code shall not be subject to the requirements of Section 1380 upon the submission to the director of the medical survey audit for the same period conducted by the State Department of Health Services as part of the Medi-Cal contracting process, unless the director determines that an additional medical survey audit is required.~~

~~SECTION 1. Section 1380.3 of the Health and Safety Code is amended to read:~~

~~1380.3. (a) Notwithstanding Section 1380, and except as provided in subdivision (b), a plan that provides services solely to Medi-Cal beneficiaries pursuant to Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code shall not be subject to the requirements of Section 1380 upon the submission to the director of the medical survey audit for the same period conducted by the State Department of Health Care Services as part of the Medi-Cal contracting process, unless the director determines that an additional medical survey audit is required.~~

~~(b) A plan that provides services solely to Medi-Cal beneficiaries pursuant to Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code shall not be exempt from Section 1380 with respect to quality management, utilization review, timely access, network adequacy, and any other requirements related to access and availability unless the department and the State Department of Health Care Services jointly make a public determination that the medical survey audit for the same period conducted by the State Department of Health Care Services as part of the Medi-Cal contracting process assures compliance with the access and availability requirements of this chapter.~~

~~SEC. 2.~~

SEC. 3. Section 1380.4 is added to the Health and Safety Code, to read:

1380.4. ~~(a)~~ A plan that provides services to Medi-Cal beneficiaries pursuant to Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code shall ~~be~~ *do both of the following:*

(a) Be surveyed under Section 1380 ~~separately with respect to those products~~ *by its Medi-Cal managed care product line distinct*

from its other product lines, if any, in order to determine whether the services received by Medi-Cal beneficiaries ~~through those products~~ comply with the requirements of this chapter.

~~(b) If a plan provides services solely to Medi-Cal beneficiaries pursuant to Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, compliance with Section 1380.3 shall satisfy the requirements of this section.~~

(b) Be annually reviewed, with respect to its Medi-Cal managed care product lines, for compliance with all of the following:

(1) Accessibility and availability of services, including network adequacy and timely access to care.

(2) Continuity of care.

(3) Quality management, including precautions to ensure that appropriate care is not withheld or delayed for any reason.

~~SEC. 3.~~

SEC. 4. Section 1380.5 is added to the Health and Safety Code, to read:

1380.5. *(a)* A plan that provides services to enrollees in the California Health Benefit Exchange pursuant to Title 22 (commencing with Section 100500) of the Government Code shall ~~be~~ *do both of the following:*

(1) Be surveyed ~~separately~~ under Section 1380 ~~with respect to those products~~ *by its product line sold through the Exchange distinct from its product line sold outside the Exchange, if any,* in order to determine whether the services received by ~~those~~ *the Exchange* enrollees ~~through the products~~ comply with the requirements of this chapter.

(2) Be annually reviewed, with respect to its product line sold through the Exchange, for compliance with all of the following:

(A) Accessibility and availability of services, including network adequacy and timely access to care.

(B) Continuity of care.

(C) Quality management, including precautions to ensure that appropriate care is not withheld or delayed for any reason.

(b) This section shall not apply to either of the following:

(1) A plan that uses the same network for its product line sold through the Exchange as the network used for its product line sold outside the Exchange.

(2) A plan that uses the same network for its product line sold through the Exchange as the network used for its Medi-Cal managed care product line.

~~SEC. 4.~~

SEC. 5. Section 1380.6 is added to the Health and Safety Code, to read:

1380.6. ~~Notwithstanding Section 1380.3, a~~ *A* plan that enrolls Medi-Cal beneficiaries as a result of any of the following shall be surveyed annually under Section 1380 with respect to *the populations enrolled in* those products until five years after the completion of initial enrollment under those products:

(a) The transition of Healthy Families Program enrollees to the Medi-Cal program pursuant to Chapter 16.2 (commencing with Section 12694.1) of Part 6.2 of Division 2 of the Insurance Code.

(b) Article 2.82 (commencing with Section 14087.98) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(c) Section 14182 of the Welfare and Institutions Code.

(d) ~~Section~~ *Sections* 14182.16 *and 14182.17,* or ~~14232.275~~ *Section 14132.275,* of the Welfare and Institutions Code.

SEC. 6. Section 1380.7 is added to the Health and Safety Code, to read:

1380.7. The department may coordinate the surveys and reviews conducted pursuant to Sections 1380.4 and 1380.6 with the State Department of Health Care Services in order to allow for simultaneous oversight of Medi-Cal managed care plans by both departments, provided that this coordination does not result in a delay of the surveys or reviews required under Sections 1380.4 and 1380.6 or in the failure of the department to conduct those surveys or reviews.

SEC. 7. Section 14087.95 of the Welfare and Institutions Code is amended to read:

14087.95. *(a)* Counties contracting with the department pursuant to this article shall be exempt from the provisions of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code for purposes of carrying out the contracts.

(b) Notwithstanding subdivision (a), a county contracting with the department pursuant to this article shall, for purposes of carrying out that contract, be treated as a health care service plan under, and comply with, subdivision (f) of Section 1367.03 of the Health and Safety Code.

SEC. 8. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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